PA16-2006: CHRONIC IDIOPATHIC CONSTIPATION

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM
FAX OR MAIL TO:
RI PA CALL CENTER
PO BOX 25719
RICHMOND, VA 23286-8212
FAX # 1-800-390-0109

PRIOR AUTHORIZATION NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

CLIENT NAME _____ DOB: _____ SEX: M / F MEDICAID ID NUMBER:_____
PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____
PRESCRIBER OFFICE ADDRESS: _____
_____
OFFICE PHONE NUMBER ( ) _____- _____
REQUESTER NAME: _____ RN /MD /R.PH / ____
PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____
DRUG REQUESTED : _____ QTY / FILL _____

Specific Criteria is available at http://www.dhs.state.ri.us/dhs/heacre/provsvcs/mpharpa.htm or by calling 1-866-420-3874

DOES THE PATIENT HAVE AT LEAST TWO CONSTIPATION ICD-9'S SUBMITTED FROM 3 MONTHS TO 2 YEARS AGO IN ADDITION TO AT LEAST ONE ICD-9 SUBMITTED IN THE LAS T 3 MONTHS? YES / NO

DOES THE PATIENT HAVE AT LEAST 1 CLAIM FOR A PRESCRIPTION LAXATIVE IN THE LAST 6 MONTHS? YES / NO

HAS THE PATIENT TRIED AND FAILED AT LEAST 2 DIFFERENT LAXATIVES (STIMULANTS OR FIBER LAXATIVES)? YES / NO

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____
By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

RI PRIOR AUTHORIZATION CALL CENTER FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)
RI PRIOR AUTHORIZATION CALL CENTER PHONE NUMBER 1-866-420-3874
RI PRIOR AUTHORIZATION - CALL CENTER HOURS
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)

PA # _____ **APPROVED**_____ **DENIED** _____ **PENDING ADDITIONAL INFORMATION**_____
DATE /TIME OF RECEIPT _____ **DATE/TIME RESPONSE** _____ **REVIEWER** _____
COMMENTS: